HEALTH CARE REFORM:

IMPACT AND IMPLEMENTATION FOR IOWA MEDICAID

Health Care Reform Overview

- The Patient Protection and Affordable Care Act (ACA, also known as “Health Care Reform”) was signed into law March 23, 2010
- This comprehensive health care reform bill is complex. Key changes to promote access to insurance include:
  - Development of ‘Exchanges’ for individuals to purchase insurance
  - Tax subsidies to assist those between 100% - 400% of the Federal Poverty Level to purchase insurance
  - Medicaid Expansion to 133% of the Federal Poverty Level for lowest income
  - Individual mandates to have insurance
  - Many other changes…
- This presentation focuses on the Medicaid impacts

Medicaid Eligibility Today

- Over the history of Medicaid, many populations have been excluded from eligibility, no matter how poor

- Federal law mandated certain 'categories'
  - Pregnant women
  - Children
  - Disabled persons (per Social Security disability determination)
  - Persons over age 65
  - Parents with dependent children
  - Some specialized categories, e.g. women with breast and cervical cancer

- Medicaid eligibility has always been complex. Iowa has over 25 different income/eligibility groups with varying income/asset guidelines for each group

Medicaid Eligibility Today

- Single adults and childless couples have always been excluded, no matter how poor
- The only way to cover adults has been through 1115 waivers, like our IowaCare waiver, but 'budget neutrality' is required, benefits and funds are capped
- Income guidelines for some categories are very low. Iowa's income limit for working parents is 75%, while their children can be covered up to 133% FPL, and up to 300% FPL through *hawk-i*
- **The ACA removes the categorical restriction in Federal law and mandates Medicaid coverage for ALL individuals up to 133% FPL**

ACA - Medicaid Expansion

- The Medicaid Expansion will increase Medicaid enrollment in Iowa by approximately 25% (80,000 to 100,000 Iowans) in 2014

- The ACA also mandates fundamental changes in how the program operates, including:
  - New income standards & eligibility guidelines
  - New procedures for accessing the program
  - New benefit design
  - Modified reimbursement methods
  - Changes to federal regulations for program policies and guidelines

Medicaid Coverage Expansion: 'Who'

- Staggered implementation
  - April 1 (now) – option for states to expand Medicaid to 133% FPL for ALL populations, but at current state/federal match rates
  - January 1, 2014 – mandatory expansion to 133% FPL

- Financing – "Newly eligible" enrollees
  - 2014 to 2016 -100% federal funds
  - 2017 to 2020 – rate decreases on a schedule to 90%

Medicaid Coverage Expansion

- Other changes related to coverage:
  - Expands Medicaid for foster children to age 26
  - Children of state employees can now be covered under CHIP (our *hawk-i* program)
  - CHIP continues through September 30, 2019
  - Maintenance of effort – all states are prohibited from reducing or restricting eligibility until 2014

Changes to 'How'

- ACA significantly restructures 'how' Medicaid eligibility will be done
  - Dramatically different way of counting income: **"Modified Adjusted Gross Income" (MAGI)**
    - Today = gross household income
    - MAGI is based on income tax guidelines (it is very different)
  - **New requirements for streamlining eligibility procedures**:
    - Must develop a system to apply for and enroll in Medicaid, CHIP, tax credits all through the Exchange
    - Consolidated applications
    - Web-based application and enrollment
    - Hospitals may perform presumptive eligibility
  - No asset/resource tests for newly eligible and current adult and children groups

Medicaid Impact in Brief

- **The Medicaid expansion plays a key role in the coverage strategy of the ACA for the lowest-income individuals**
  - Nationally, the Medicaid expansion will result in millions of low-income childless adults, parents, and children now covered through CHIP becoming covered by Medicaid
  - Also, expected increases in enrollment for those currently eligible as they learn about coverage and sign up
  - The federal government will finance the majority of the cost of the new Medicaid coverage. Congressional Budget Office estimates federal financing will cover 96% of the cost (*Kaiser Family Foundation May 2010*)
  - Individuals over 133% FPL (perhaps even those currently covered by Medicaid) will transition to purchasing coverage through the Exchange

Impact on Iowa Medicaid

- Expand Eligibility
  - Will enroll 80,000 to 100,000 Iowans in a new 133% FPL eligibility group, estimated up to 150,000 by 2019 by some sources
  - Must define a benefit structure/covered services package (a "benchmark" plan), may be the same as current Medicaid coverage (we think)

- Transition New Coverage
  - Transition of IowaCare – the 1115 waiver/IowaCare will end December 31, 2013 and members will transition to the Medicaid expansion (for those below 133% FPL) and to subsidies/Exchange for those above 133% FPL
    - The majority of IowaCare members are below 100% FPL
  - Eligibility groups above 133% FPL may transition from Medicaid to the Exchange. Policy makers will need to decide whether/if/how they want to do that

2014 not 3 years, it is tomorrow!

- **Iowa has a 30 year-old legacy mainframe for eligibility processing and limited web-based functionality. Today nearly all eligibility work is performed in the local DHS offices and is reliant on manual processes. ACA requires us to:**
  - Redefine Income Standards
    - For majority of Medicaid eligibility categories, must adhere to a new "modified gross income " standard
    - Must determine whether all categories continue and/or change
  - Develop New Eligibility Determination Processes ("Eligibility Gateway")
    - Implement single application for Medicaid, CHIP and premium subsidies
    - Establish seamless eligibility between public and private programs
  - Establish processes to coordinate with the "Exchange"
    - "Re-engineer" eligibility processing in connection with the Exchange
    - Determine eligibility for tax credit programs through the Exchange
    - Develop system for Medicaid enrollment through the Exchange and hospitals

- **The ACA requirements will streamline and 'modernize' eligibility processing for Medicaid, but it will be a steep climb to accomplish with significant IT system impacts.**

Unknowns

- Significant amounts of federal guidance is going to be needed soon
- The IT impact analysis is almost impossible to start without knowing the details of how this is going to work
- CMS is working hard to develop guidance, but much is unknown
- States especially need to know the details for MAGI – key decisions will drive system design

Other Impacts

- Implement new fraud and reporting requirements (Program Integrity)
- Analyze other Federal policy changes Implemented as a result of ACA
  - Review for impact to other federal and state programs administered by Iowa DHS
  - Address operational details required for successful implementation
  - Develop, implement, test and train for IT systems
- Identify impact to IME operations
  - New benefit package
  - Provider network/capacity
  - Reimbursement impacts
  - Operational impacts due to increases in population/volume

Opportunities to Evaluate

- The ACA includes provisions that are not mandatory, but include those that could assist states to implement improvements or re-balancing, such as:
  - New State Plan options
  - Improvements in health care programs
    - Mental Health
    - Long Term Care
    - Early Childhood Programs
  - Demonstration grants
  - Payment reform initiatives
  - Integration of Other Transformation Initiatives
    - Medical Home
    - Health Information Technology (HIT)
    - ICD-10 conversion

Fiscal Impact

- Many “unknowns” remain; much yet to be determined
  - Potential for *increased* costs to state:
    - Mandatory Medicaid expansion
    - Costs associated with developing and operating the “Exchanges”
    - Changes to eligibility systems & interoperability with “Exchanges”
    - Restructuring of drug rebate programs
    - Reduction in Disproportionate Share Hospitals (DSH) payments
  - Potential for *decreased* costs to state:
    - Enhanced FFP
    - Shifting current Medicaid populations in part or in whole to the Exchange
    - Long Term Care options available that would not need Medicaid financing
    - New Medicaid coverage available, providing coverage for those currently served in state-only or county-only funded programs

Resources

- Final health care reform law is now published as one document. Below is a link to the final consolidated health care reform law (combines the provisions of the Patient Protection and Affordable Care Act (PPACA) and consolidating amendments):

http://docs.house.gov/energycommerce/ppacacon.pdf

- New federal website:

www.healthcare.gov

QUESTIONS?